laryngeally not even by means of the galvano cautery, by means of which new dangers could easily be brought forward, as perichondritis, necrosis.

The removal of the tumor can only be done extralaryngeally. The method of operation is different, according to the seat of the tumor. If its site be in the plate of the cricoid cartilage, then a partial excision of the cricoid cartilage is rendered difficult, as 1, the tumor, even if it is seated upon the side of the cartilage, is never confined to the one side of the cartilage but sometimes arises from the center; 2, the tumor sometimes not only is confined to the larynx but also may extend into the pharynx, where the anterior pharyngeal wall would not be spared. Billroth "enucleates" the tumor from the neck by means of subhyoid pharyngotomy, but he soon observed a recurrence. Boecker removed the tumor by tracheo-laryngotomy, with the entire cricoid cartilage, leaving the arytenoid cartilage and the vocal cords. Putelli recommends this method of operation; after which the patient (5 weeks after) left the hospital, and with a tracheal canula, with but little trouble in breathing and phonation — *Wein. Med. Jahrb., N. F.*, III, 7, p. 351, 1889.

F. H. PRITCHARD (Boston)

CHEST AND ABDOMEN.

I. A New Method of Operating for Thoracic Empyema. By Dr. M. SSUBBOTIN. In cases of long standing empyema, in which plastic measures for securing obliteration of the pleural cavity by collapse of the chest walls are indicated, the author successfully performed the following operation: A portion of the 7th rib (6 to 8 ctm.) is resected in the usual manner, and the pleural cavity is opened and thoroughly irrigated. This opening is packed in order to prevent septic infection. A longitudinal incision is now made upon the external edge of the pectoralis major muscle, of about 5 ctm. in length, by means of which latter the author bares the 6th, 5th and 4th ribs. Without removing the periosteum, from each of these ribs a small wedge is resected, so that the rib becomes movable at this point. A similar longitudinal incision is now made in the posterior axillary line, and at

this point the above mentioned ribs are treated in a similar manner. These vertical incisions have no connection with the pleural cavity, and are sutured at once, without damage. The portion of the chest wall lying between the longitudinal incisions now sinks in, and, as the healing process advances, becomes fixed in this depressed position, serving the double purpose of protecting the chest cavity and prevent ing, in some measure, the scoliosis which occurs so commonly after operations for empyema.—*Vratch*, 1888, No. 45.

G. R. FOWLER (Brooklyn).

II. Operation for Relief of Congenital Diaphragmatic Hernia. By DR. J. O'DWYER, of New York. A child, æt. 3½ years, had symptoms supposed to indicate extensive empyema of left side, for the relief of which an opening was made in the 6th intercostal space. The escape of a loop of small intestine through this opening showed the real nature of the case. The intestine was returned and the wound closed. On the next day Dr. O'Dwyer proceeded to operate for the relief of the diaphragmatic hernia. He made an incision about two inches long in the tenth interspace, and found an aperture situated in the muscular portion of the diaphragm, about one inch and a half in diameter, the external margin reaching close to the ribs. He then removed about three inches of the 9th and 10th ribs, and by drawing down the floating ribs, ample room to insert the whole hand, if necessary, was obtained. Considerable difficulty was experienced in replacing the intestines, owing to the small size of the peritoneal cavity, from retraction of the abdominal muscles. The cæcum and some of the omentum were the last parts reduced. To prevent a return of the intestines while paring the edges of the wound and passing the sutures, two flat sponges, attached to holders, were found necessary. Strong braided silk was used for this purpose, and six sutures inserted. When the diaphragm was allowed to resume its position, after the completion of the operation, the pressure from below was so great that it bulged upward, so as to fill at least half the pleural cavity. The hernia being probably congenital, and the whole mass of intestine, with the exception of the descending colon, having occupied the